CONSENT FOR TREATMENT

Name_____ Date_____

I consent to treatment for my tuberculosis exposure, latent TB infection, and/or active TB disease with the following drugs: (Circle drug client is on and enter dosage and frequency)

1. Isoniazid (I)_____ 2. Rifampin (R) _____ 3. Pyrazinamide (Z) _____

4. Ethambutol (M)_____ 5. Streptomycin (S) _____6. Rifapentine (P) _____

7. Vitamin B6_____ 8. Other_____ 9. Other_____

These are some of the **possible side effects:** (Circle side effects that apply for drug(s) patient is taking)

Rash, itch, hives (I, R, Z, M, S, P)	Fever or chills (I, R, P, M, S)	G.I. upset or diarrhea (I, R, P, S, B6)
Yellowing of eyes or skin (I, R, Z, P)	Mental changes (I, R, P)	Sore throat, mouth or tongue (I, R, P)
Unusual bleeding or bruising (I, R, P)	Coffee colored urine (I)	Numbness of face (S)
Unusual tiredness or weakness (I, Z)	Loss of vision or eye pain (I, M)	Red/orange tears, sweat or urine (R,P)
Clumsiness or unsteadiness (I, S)	Red-green color blindness (M)	Swelling around eyes/face (R, P)
Dizzy or sleepy (R, P, S, B6)	Decreased hearing (S)	Interfere with contraceptive (R, P)
Sores on skin or in mouth (R, P)	Muscle or bone pain (R, P)	Pain, numbness, tingling or burning in hands, feet, or joints (I, M, B6)

These possible side effects have been fully discussed with me by the physician and/or the nurse. The benefits of this therapy have been explained to me, as well as the importance of taking the medication(s) regularly and consistently as recommended. I also understand that Directly Observed Therapy (DOT), where the nurse or an agreed upon responsible person watches me swallow my medication, is a nationally recognized standard of therapy.

I understand that the drugs Rifampin and Rifapentine interfere with both contraceptive pills and injections and I will need to use other birth control measures if the possibility of pregnancy exists. I have informed the physician if I am using contraceptives.

I understand that most people can take the medication(s) without difficulty, but if I should develop any of the symptoms listed above, I am to contact_____at _____ and ask to speak with the nurse**. I AM NOT TO WAIT UNTIL MY NEXT CLINIC APPOINTMENT**, but am to call right away for instructions for follow-up of my symptoms.

_____ _____

Signature of Patient, Parent or Legal Guardian Signature of Health Professional Obtaining Consent

_____ _____

Relationship (if signature not patient) Health Department